Maine Department of Labor
UNEMPLOYMENT COMPENSATION DIVISION

REQUEST FOR DETERMINATION OF ENTITLEMENT TO DISLOCATED WORKER'S BENEFITS

Claimant's Name (Last, First, Middle)	Social Security No.	Telephone No.
Address (No. and Street, City or Town, County, State, Zip Code)		
Last/Current Employer	Last/Current Occupation	

A. OTHER QUALIFYING INFORMATION

1. Have you filed an application for a determination to Dislocated Worker's Benefits prior to this application? .....[ ] YES [ ] NO
   If "YES," Date Filed_____

2. Were you paid Dislocated Worker Benefits prior to this application?.....[ ] YES [ ] NO
   If "YES," Last Date Paid_____

3. Are you currently collecting Unemployment Insurance Benefits or have you exhausted Unemployment Insurance Benefits in the 30 Months prior to enrollment? .....[ ] YES [ ] NO
   If "YES," Paying State_____

4. Are you now employed or have you been employed within the last 30 months? .....[ ] YES [ ] NO

   If "YES," Employer's Name_____

   Address_____

   Have you been given a definite or indefinite recall date?.....[ ] YES [ ] NO

   If "YES," Date of Recall_____

5. What was the reason for separation from the last employer? Check one: [ ] Lack of Work; [ ] Discharge; [ ] Voluntary Quit; [ ] Other, Please Explain_____

6. Are you enrolled or attending training? .....[ ] YES [ ] NO

   If "YES," Training Facility_____

   Address_____

   Date Training Began_____

6A. Do you have a Training Sponsor?.....[ ] YES [ ] NO

   If "YES," Name of Training Sponsor_____

B. STATEMENT REQUIRED UNDER THE PRIVACY ACT OF 1974 FOR THE DISLOCATED WORKER PROGRAM: Information requested for use by the Maine Department of Labor and the U.S. Department of Labor is authorized under Section 806 of the Social Security Act (42 U.S.C. 1106). All information furnished (including Social Security Number) is voluntary and will be kept confidential to the extent that release of all such information is authorized in the processing of this application and will not be released or used for any purpose other than for establishing entitlement to benefits and allowances under the Dislocated Worker Program for statistical and research studies and to insure that benefits have been paid properly.

C. WORKER CERTIFCATION: I give this information to support my request for a determination of entitlement to Dislocated Worker Benefits. The information contained in this request is correct and complete to the best of my knowledge. I understand that penalties are provided for willful misrepresentation made to obtain benefits to which I am not entitled.

Signature of Worker	Date of Request

D. STATE AGENCY CERTIFICATION: I have witnessed the claimant's signature shown and have discussed with the claimant the statements made.

Signature of Agency Representative	Date